OMB#: 0925-0584
Exp. xx/xx/xxxx

HCHS/SOL Visit 2 Participant Disability Screening Form

ID NUMBER:									FORM CODE: PDE VERSION: 1, 06/03/2014	Contact Occasion	0	2	SEQ #	0	1

ADMINISTRATIVE INFORMATION

0a. Completion Date (mm/dd/yyyy): ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: *This disability screening form must be completed after informed consent administration and before the participant has their examination. Positive responses to Questions 1 – 6 should be noted on the Exam Itinerary Checklist for routing purposes during the visit.*

Introductory Script for staff: *Now I would like to ask you about difficulties you may have in usual activities of daily living:*

A. Disability Status

1. Are you deaf or do you have serious difficulty hearing?

   No 0 ☐
   Yes 1 ☐

2. Are you blind or do you have serous difficulty seeing, even when wearing glasses?

   No 0 ☐
   Yes 1 ☐

3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

   No 0 ☐
   Yes 1 ☐

4. Do you have serious difficulty walking or climbing stairs?

   No 0 ☐
   Yes 1 ☐

5. Do you have difficulty walking one half mile (approximately 1 kilometer)?

   No 0 ☐
   Yes 1 ☐

6. Do you have difficulty climbing 10 stairs?

   No 0 ☐
   Yes 1 ☐

7. Do you have difficulty dressing or bathing?

   No 0 ☐

   Yes 1 ☐

8. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping ?

   No 0 ☐

   Yes 1 ☐